Spending Cap Subgroup
November 17, 2015
Meeting Minutes

Attendees:
Elizabeth Roberts, Al Charbonneau, Mark Montello, Lou Giancola, Neil Steinberg, Al Kurose, Lauren Connelly, Mike Souza, Joe I, Sam Salganik, Elizabeth Lange, Marti Rosenberg, Sarah Nguyen, Pat Ross , Cory King, Rele Abiade, Sam Marullo, Nicole Alexander-Scott, Sophie O'Connell

I. Introduction & Welcome--Secretary Roberts.
Secretary Roberts welcomes everyone to the meeting and thanks them for coming. Attendees introduce themselves. Secretary Roberts reviews upcoming meetings.

II. Ancillary Policy Proposals
Secretary Roberts – Reminds everyone that the proposal being developed will be a recommendation to the governor. Reviews policy directions that discussions around reforming healthcare in RI have focused on in recent years, including 1) moving away from the volume-based fee-for-service structure and towards paying for value; 2) Investing in cost-effective alternatives; and 3) aligning other policies statewide. (Presentation slides available upon request by emailing lauren.lapolla@health.ri.gov) There is an understanding that change is needed to manage costs more effectively.

III. Comments on draft spending cap proposal

Neil Steinberg – Raises the importance of an effective communication strategy to sell and describe the proposal to those who will be impacted.
Secretary Roberts – We hear you. Describes current work with OHIC to examine premium increases.

Lou Giancola – Refers to discussion at last meeting related to having a central infrastructure to implement the policy changes, and what changes that will require.
Secretary Roberts – Acknowledges discussion last week; clarifies that today we are focusing on ancillary proposals that will run alongside it.

Lou Giancola – Need to look at how it will be different from what exists now.
Secretary Roberts – Currently looking at resources we have now across government and related entities, and what gaps exist. Reminds group that they are developing a recommendation for direction, while some areas of detail will be left for review and discussion by the Governor and the legislature.

Mark Montello – There are serious questions about the implications of this proposal for the regulatory framework that exists now. Existing distortions have major implications around

driving towards lower cost, and other public good aspects of the delivery system. Provides example of how regulations differ for an ambulatory surgery center with respect to building codes, Joint Commission, due to differing infrastructure, which results in some entities having a cost advantage (everyone is not competing on a level playing field). These distortions have not been addressed, nor have standby costs of academics and other public goods. If we're talking about a spending target, which is aspirational in nature, why do we need an enforcement mechanism?
Secretary Roberts – Enforcement and accountability are two different approaches. Those comments have been heard and are being thought through. We are looking at an accountability structure, rather than a penalty structure. We heard concerns that accountability may wander towards enforcement. There have been many industry discussions regarding different regulatory structures for different entities. The reality is those trends are moving and probably accelerating. Most hospitals are likely looking at how this works as a business model going forward, and the payers are looking at how to serve people in the most cost-effective way. Those are the balancing acts that regulators and payers have to have. Inpatient hospitalization will likely continue to decline, and as a payer [through Medicaid], we are interested in that. References fact that RI has one of the highest rates of avoidable admissions in the country.

Al Charbonneau – I'd like to see a focus on hospitals that is less regulatory and more experimental. A better approach is one where you challenge providers to experiment, and create an environment where you allow them to do that legally.
Secretary Roberts – We are looking, especially with the SIM initiative, at regulatory structures to make sure they're appropriate. Some are outdated.

Al Charbonneau – If you start an Office of Health Policy, it runs a high risk of dealing with marginal things, versus if you really challenge providers so they feel responsibility for managing experiments, you may have different outcomes.
Secretary Roberts – Asks for an example of what is not being seen in our environment right now. We are doing some of that with Medicaid and other initiatives.

Al Charbonneau – Inpatient takes up too much of the existing dollars. Consider telling hospitals to come up with an alternative. If you structure and experiment in an environment where providers, hospital trustees, etc. have a stake in the game, you may get a better result.
Secretary Roberts – I see the growth of ACOs in our state as a provider-driven set of changes, in partnership with the payers. We are letting the providers innovate in partnership with the payers.

Al Charbonneau – If you look at the data, there's a high risk of hospital-based ACOs being built on an inflated overhead.
Secretary Roberts – I'm more asking whether that's the type of provider-led innovation you're talking about.
Al Charbonneau – It's a possibility, but if you don't structure ACO development so it's pushed to

do better, the first round of changes you'll get is typically what can be done without much risk. Need to put some pressure that encourages risk and innovation.

Sam Salganik – Regarding the regulation of ACOs, they take on a lot of insurance risk. We have a lot of experience that shows insurance companies have incentives to reduce cost of care, and can do so in lots of ways – by seeking out patients, restricting access to care as appropriate, etc. We have a system in place to watch that carefully. As risk is pushed to providers, we need to ensure there are appropriate financial reserves so hospitals don't run out of business, and so that reforms are working. Someone should be watching this carefully.
Secretary Roberts – As a follow up to Al Charbonneau's comment, references industry group convened by Senator Whitehouse and Neil Steinberg. In my view, the policy organization is intended to be an alignment of state policy to work with the community more effectively. That's our goal, not to say Health Policy will redesign and restructure RI's healthcare system. The question is, what is it that causes the community of providers to move the conversation forward? The state can't step in and do it. We have to be a partner, and we have resources. One of our jobs is to simplify access and use of those resources, and establish policies that don't get in the way of innovation and change. The Governor is examining the possibility of putting cost pressure on the system, and aligning policies and right-sizing regulation, in partnership with the SIM project. What will change the dynamic among providers in the system?

Lou Giancola – I think you put it really well. The trick is to create a regulatory environment that fosters the appropriate kind of competition that results in innovation and achieves lower cost.
Secretary Roberts – If we think about hospitals, we'll have four or five different systems that are competitors. What will fundamentally alter that world?

Al Kurose – At a basic level, the status quo needs to be made more uncomfortable. The biggest problem we have is that the healthcare revenues in RI are 98.5% fee for service. We have to do something about that. As long as it's like that, we're not going to get the kind of disruptive change we're looking for. That's a game-defining economic reality. At the simplest level, use regulation to weaken that dynamic and let the free market competitive forces generate innovation and create solutions for pressured organizations.

Al Charbonneau – But part of what's worrisome about that is the way we compete in healthcare. Competition gets very expensive. If you structure something so that the academic is not heard... We will empower consumers to shop around – certain things are amenable to market pressures. As you begin to lead away from teaching institutions, things at the profit margins, you'll prompt some behavior that could be even more expensive. A better model may be one where people both collaborate and compete. If you were to develop a global budget, you'd immediately raise the level of sophistication in this proposal. The part that worries me about the health planning proposal is if you can't get a real good focus on what the problems are, the planning will start off in left field. We have problems with institutions doing the same

thing they've been doing for 50 years, and you need to figure out where they need to go, so people in charge of these institutions may see something better.

Al Kurose – You raise many legitimate higher-order concerns, but we need to think about what we can do first, what is most basic and which can have an impact, before we take additional steps and be more creative. Fee for service is one basic problem we have. I agree with your proposals, but they're harder and will take longer. We're missing that fundamental first step. Is there anyone who thinks that further fee-for-service increases are a good idea?

Al Charbonneau – I disagree that the things I'm talking about take a long time. If you were to adopt a collaborative model based on hospital costs, you could take 50-60% of the expenses and turn them from fee for service to something else.

Al Kurose – Do you think that will actually happen?

Al Charbonneau – Part of the collaborative model is to help stabilize hospital expenses so hospitals can focus on these changes.

Secretary Roberts – Just to orient us, the Governor directed us to think about whole system, not just hospitals. I have a question about whether there is an interest at this point in that kind of collaborative approach to thinking about the whole system on the hospital side, versus a competitive approach. I'm not sure I see an environment where all the hospitals want to engage in the collaborative model.

Mark Montello – This is the problem with the regulatory framework. The Feds said competition in healthcare will solve the problem. Describes how this is at odds with FDC enforcement mechanisms. This is not a defense of the status quo, it's a question about various state and federal regulatory agencies that have prerogatives and operate on them. Some are still based on conflict over whether competition or more regulation will solve the problem. And nobody has the answer. We've been operating on caps for several years… there is already cost pressure. The question is over additional pressures. Let the data start to determine what it is, and make a decision. Academics is still an issue we're not talking about. How do we want to scale it? How do we want it to look? Where does the question of how we feed and support them come in? Now it [graduate medical education] is only being supported by Medicare. How do we synthesize regulatory philosophies so we can move forward? Ultimately we're all ending up moving into the insurance business. At some point in time we'll trip the Department of Health managed care statute, and there will be actuarial concerns.

Secretary Roberts – Understanding the litany of challenges, is there an interest in government creating a shared approach to solving them? Or should we just set regulations and let competition sort it out?

Comment – To be aggressive, you need some financial backing. When we talk about the ACO or AE, which I believe is the right model, the thing we don't talk about is the entities funding the AEs and how they need to make money. The only way it can work is to bring more patients in, and take business away from others. There isn't enough in this state for 4 or 5 systems to be successful with the AE model. If you just drive down utilization, legacy entities can't pay our fixed costs anymore. To be aggressive with getting away from fee for service, we need to be financially viable.

Secretary Roberts – I think the fundamental question I have as chair is, will what we're looking at drive the change in the market that we need? What is the driver for that change?

Al Charbonneau – The state needs to lay out, in a couple bullet points, data on premium increases so it's easy to understand. That begins to prompt pressure on people that run the system and on organizations to try to do different things. It might drive people to compete in an expensive way. We need to drive competition based on price. The other option is to drive collaboration. But what we're not doing is driving substantive change that drives the premiums we think we need.

[Secretary Roberts departs for another meeting; Sam Marullo facilitates end of meeting.]

IV. Group Discussion

Sam Marullo – Mentions we're also accepting comments on the draft proposal by email through the end of the week. Asks for additional comments on the overall proposal.

Mark Montello – Moving from volume to value has to go back to volume. Unless you take massive amounts of fixed costs out of the system, it's not going to work. We need a massive philosophical shift, because volume is still required to move to value, and value is still going to require volume, because organizations need the capital. This is not a new problem. We need to really do something out of the box.

Comment (Joe?) – It's very difficult to be aggressive and take risk when you don't have the reserves to do so.

Lou Giancola – Regarding the collaborative approach, Al, can you outline your three steps? There seems to be a consensus that the cap won't do much, except as a way to monitor things. How do we have a substantive discussion of which of the three models the state should be pursuing? The role of SIM is to facilitate that policy direction, and our responsibility is to advise and give input to the Governor.

Mark Montello – I think lack of progress is due to a collision of outcomes that nobody wants to reconcile. We let data drive it, but then when the data become a problem or we don't like what it says, we go for an impressionistic approach. Then we go back to data, and we can't reconcile

the political and healthcare issues. The reality is it's not about healthcare, it's about economics. We don't want to lose jobs. And RI is disproportionately dependent on healthcare for its gross state product. We need to come up with a series of principles that incite real change.

Sam Marullo – We'd love to see your recommendations for how we can do that.

Mark Montello – We've been recommending things for many years. You need to say we're making big changes, and we'll react accordingly – like downsizing.

Al Charbonneau – At the 5000 foot level, we need to look at what's true. Take off the table the idea that I'll lose my job. It may be a job at a different institution. We're talking about real change. And if you can make those difficult decisions, occupancies can get up to 50 to 80 percent.

Lou Giancola – One thing is to get the board chairs at the table when we talk about taking capacity out of the system. And to facilitate a role for those institutions. But the bankruptcy laws don't really foster that.

Sam Marullo – Unfortunately we are out of time. Thanks group.

V. Public Comment

No additional public comments. Additional comments can be sent via email to sam.s.marullo@governor.ri.gov